Written comments submitted to the Department of Health Care Services (DHCS)
Regarding the Transfer of the Drug Medi-Cal Program to DHCS, effective July 1, 2012

Comments received through July 17, 2011

Note: in some cases, DHCS has edited the responses to explain the acronym used by the writer.

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I was at the 13 July Drug Medi-Cal (DMC) stakeholder meeting, and I would like to add a couple of points:

1. I think it would be helpful to involve county and provider level IT, patient accounting and finance staff. These are the folks doing the hands-on management of the revenue cycle at the local level. They will be able to provide important technical information about how the process works and point the way for areas of improvement. They are also the people best qualified to provide advice and feedback on the transfer process. In most counties Mental Health (MH) and Substance Use (SU) divisions use the same billing system.

2. I would also like to second the point made by one of the attendees about having both MH and SU stakeholders in the same room at the same time.

3. The focus of the 13 July meeting was, appropriately, just the DMC transfer. However, the transfer is happening in an environment filled with changes. There is the hastily conceived realignment currently in process. Within the 1115 Waiver LIHP, 8 counties are beginning the implementation of SU add-on services, testing new models for reimbursement and primary care integration. In January 2012, the 1115 Waiver Behavioral Health Needs Assessment draft will be available for comment. All this is happening as the Substance Use Disorder (SUD) field is preparing for 2014. Towards the end of the meeting there was some discussion about having an advisory group that would be looking strategically at how these different activities might work complementarily towards a common goal. I think this would be a good idea.

4. Finally Vanessa Baird asked me to submit the document I was reading when commenting at the 13 July meeting. I have attached these talking points (found immediately below). Many are outside the scope of the current project transitioning DMC to DHCS but will be on table when the transfer is complete and the SUD field asks, "What now?"

In General –

- Is the process intended to result in an essentially status quo DMC system or will DHCS use the opportunity to create basic improvements in advance of any recommendations that may come out in the 1115 Waiver Behavioral Health Services Needs Assessment and Plan?

- With realignment, the need for managed care in DMC is greater than ever. Is a 1915(b) waiver a possibility? With managed care, as in the mental health system, some state level responsibilities will devolve to counties. Does it make sense to set up infrastructure within DHCS that may shortly be handed down to counties?

- Changes in state and county responsibilities under realignment notwithstanding, how is DHCS going to ensure that the institutional knowledge base within ADP is maintained, both in the DMC transition and beyond?

- Does DHCS have a high level vision of what DMC will become after the transition is complete? It is probably too soon for DHCS to provide much in the way of specifics but, for example:
    - are they considering a combined MH/SU benefit;
    - is the rehab option on the table for SUD;
    - does DMC remain a carve-out;
    - is managed care part of the picture;
    - are they willing to make the investment in SU benefits that attract providers and adequately finance effective science-based treatment?

- Hopefully we can all be strategic in this process, looking ahead to what happens after the transition.

- What does DHCS want from the field in this multi-year process?

- When does DMC Certification and Narcotic Treatment Program (NTP) oversight move to DHCS?

1) What are your comments on the organizational placement of the Drug Medi-Cal Program and behavioral health leadership within DHCS?

This question assumes that all DADP functions will be incorporated into DHCS at some point. A strong and effective focus for policy must be present. How will DHCS ensure that this leadership provides adequate and ongoing attention to SU relative to the much larger MH system? This will require effective advocacy for the field within state government and credible stewardship of the statewide community-based system of care as we move into health care reform.

2) What are your recommendations regarding the roles of Drug Medi-Cal stakeholders and interactions between stakeholders and:
a) DADP and DHCS during the transfer period? and
b) DHCS on an on-going basis?

Counties, providers and clients live in the real DMC world where regulations, services, staff, payments, and the needs of people with substance use disorders all intersect. They have an understanding of the operational aspects of DMC that DHCS needs. Workgroups should be established to track and provide feedback on local level impacts of the transfer of key components, e.g., claiming, cost reporting, data collection and program standards. The real work starts after the transfer. This should be a transformation of DMC. DHCS will need the accumulated experience of the field to make this a success

3) How can DHCS and DADP best ensure continuous and uninterrupted administrative supports to drug and alcohol treatment service providers pre and post transfer of the Drug Medi-Cal Program?

Move the money, adjudicate and pay claims efficiently; Ensure a thorough knowledge transfer occurs; DHCS first needs to understand this small but complex carve-out; Identify areas for improvement in the current process; Be sure that auditors, if they are not redeployed ADP staff, are knowledgeable.

4) What proposed Drug Medi-Cal Program changes and efficiencies do you recommend DHCS and DADP consider in this initial phase of the DMC program transfer?

The greatest efficiency is achieved when the state does not have to perform a given function at all. Under realignment, the question is whether any of current ADP responsibilities can be passed down to counties; for example provider certification, program standards, post-service post-payment utilization review without a managed care waiver. Are changes to law or to Title 22 or Title 9 (NTP's) on the table? Otherwise Task #1 is making a smooth transition (See #3.) The proceeding notwithstanding, DMC needs to be completely redesigned. There are certainly improvements and efficiencies to be made on the margins but it would be a mistake to build a new system on top of DMC. Better to start with a clean slate.

5) Considering the above questions, what are your priorities for discussion in future meetings?

Behavioral Health Needs Assessment and Plan - the post-transfer plan for Drug Medi-Cal reform, including:

- A 1915(b) managed care waiver.
- Benefits that reimburse science-based services.
- Reimbursement that covers the cost of services.

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On Question #1, regarding the organizational placement of behavioral health leadership under DHCS, the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) recommends a single state "division" for Mental Health/Substance Use Disorders, wherein both fields would maintain a distinct identity, while collaborating on integrated services at the local level – not only integrated co-occurring services for MH & SUD, but also integration of both fields with primary care. This model would be akin to the Substance Abuse and Mental Health Services Administration (SAMHSA) model at the federal level. Rather than calling this division "Behavioral Health," we propose a title such as "Division of Substance Use Disorders and Mental Health," which would more accurately reflect the services provided by our respective fields. We would also propose that this division be led by a Deputy Director who is equally experienced and articulate in both MH and SUD issues and would be a strong statewide advocate for both fields. Under this Deputy Director there should be a unit for Mental Health Services and a unit for Substance Use Disorder Services, led by individuals who (1) have the ability to move our fields forward in health care reform; (2) provide direction across all state departments that are affected by MH & SUD; (3) understand and can address federal issues (especially federal maintenance of effort [MOE] requirements) and can develop linkages to

federal structures; (4) can improve administrative efficiencies and provide common solutions to I.T. implementation; and (5) will be a strong voice in addressing cultural disparities.

On Question #4, regarding proposed Drug Medi-Cal changes and efficiencies that should be considered in the initial phase of the transfer, CADPAAC recommends that service claiming timelines and features for Drug Medi-Cal be synchronized and brought into conformity with claiming features of Mental Health Medi-Cal.

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1. **What are your comments on the organization placement of the Drug Medi-Cal Program and Behavioral Health leadership within DHCS?**
   - We would like to see DHCS consider hiring two deputy directors…. One for mental health and one for substance abuse versus hiring one for behavioral health only. History suggests that alcohol and drug services get lost in the combination model.
2. **What are your recommendations regarding the roles of Drug Medi-Cal stakeholders and interactions between stakeholders, ADP, and DHCS during the transfer period? And on an ongoing basis?**
   - Continue meeting with stakeholders throughout and after the transition is complete and post quarterly updates on DHCS website with key information
3. **How can DHCS and ADP best ensure continuous and uninterrupted administrative supports to drug and alcohol treatment service providers pre and post transfer of the DMC program?**
   - Continue rate setting process at the State level
   - Streamline billing procedures
   - Provide IT assistance to programs to ensure DMC compliance with EHR (electronic health records) and other Affordable Care Act (ACA) requirements
4. **What proposed DMC program changes and efficiencies do you recommend DHCS and ADP to consider in this initial phase of the DMC program transfer?**
   a. Consider elimination of Title 9 regulations
      - This will save DHCS staff time and prevent them from having to learn 2 separate sets of rules.
      - Prevents DHCS from employing someone to handle state exception requests (we would go through federal process only); **OR** Switch to electronic exceptions through SAMHSA/CSAT website so you don't have to hire someone to hover over a fax machine all day and approve frivolous exceptions
      - Title 9 regulations are very prohibitive and non-patient friendly and pose barriers to accessing appropriate treatment at times (especially in emergency type situations)

   b. Consider accepting credit cards payments for slot fees.

   c. Consider web based license renewal to save DHCS staff time
5. **Considering the above questions, what are your priorities for discussion in future meetings?**
   a. Rate setting process done on State level
   b. Elimination of Title 9 regulations OR updating State regulations to match federal regulations

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I would like to see Drug Medi-Cal pay for Methadone services and a Perinatal Residential service on the same day.
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I have two comments:

1. The current adjudication system delay needs to be improved. Currently we are at four weeks from upload to receive a denial 835.

2. The department that will be supporting direct providers and Counties with denial problems should have access to the Medi-Cal Eligibility Determination System (MEDS). Currently DADP staff does not have access to MEDS.